HONORHEALTH™

HonorHealth.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Network Support Services (NSSC)
Attn: Health Information Management – Release of Information
2500 W. Utopia, Phoenix, AZ 85027
Phone: (480) 882-4040
Fax: (480) 882-5841

❑ **For NOAH Clinics, please mail to appropriate location**

PATIENT IDENTIFYING INFORMATION:

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To:

I hereby authorize HonorHealth to release my medical record information to: ❑ Mail Copies To: ❑ Hold for Patient Pick-up
Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ❑ Personal ❑ Continuing Care ❑ Legal ❑ Other: _____

Specific Information to be Released:

Date(s) of Service: _____
❑ Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
❑ Discharge Summary ❑ History & Physical ❑ Operative Report ❑ ER Report ❑ Consultation Report
❑ EKG ❑ Diagnostic Imaging Reports ❑ EEG ❑ Lab Results ❑ Pathology Reports ❑ Diagnostic Films
(specify): _____ ❑ Complete Records: Date of Visit _____ ❑ Other (specify): _____ ❑ Family Practice Clinic ❑ Itemized Statement ❑ Account Review
❑ EHI Export machine-readable

❑ CD ❑ Paper Records ❑ MyChart ❑ Email_____

I authorize the provider to use or disclose information related to: ❑AIDS/HIV and other Communicable Diseases
❑ Genetic Testing Information ❑ Psychiatric Care Reports ❑ Alcohol and/or Drug Abuse Treatment

I understand that HonorHealth will not condition treatment on my signing this authorization. HonorHealth will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read HonorHealth's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to HonorHealth. Unless I *revoke* the authorization earlier, it will expire upon its completion or *60 days* from date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be *re-disclosed* by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description or Authority to Act for Patient